DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/26/13

PRINTED: 09/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445135	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WINDWOOD	220 LONGMIRE RD CLINTON, TN 37716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to assure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on September 9, 2013 between 6:00 a.m. and 2:00 p.m. confirmed the following doors failed to close to a positive latch: 1. The staff break room door 2. The staff Dining Services office 3. The fire door by the Admission office	K 018	K 018 Residents Affected All residents have the potential to be affected. Measures/Systemic Changes Doors adjusted to assure doors close to a positive latch. Monitoring Changes Maintenance will monitor doors daily during interior rounds for positive latch. Any future instances of non-compliance will be reported to Safety Committee Meeting (Nursing, Executive Director, Human Resource, Maintenance, Director of Clinical Education) monthly for (3) months and recommendations made as appropriate.	10/22/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Linwood
TITLE: Executive Director
(X6) DATE: 9/25/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 4. The fire door by room 222 These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 9, 2013.	K 018		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to assure exits were lighted. The findings include: Observation on September 9, 2013 at 5:50 a.m. confirmed the outside lights at the exits from the dining room exit and corridor exit by room 212 was not illuminated and missing 1 of 2 bulbs. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 9, 2013.	K 045	K 045 Residents Affected All residents have the potential to be affected. Measures/Systemic Changes Light bulbs were replaced immediately. Monitoring Changes Egress and exit discharge lighting will be monitored daily and bulbs replaced immediately if needed . Any future instances of non-compliance will be reported to Safety Committee Meeting (Nursing, Executive Director, Human Resources, Maintenance, Director of Education) monthly for (3) months and recommendations made as appropriate.	10/22/13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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K 062	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure sprinkler heads in each compartment were the same types. The findings include: Observation and interview with the Maintenance Supervisor on September 9, 2013 at 8:30 a.m. confirmed there were two different sprinkler heads in the North HVAC equipment room, one standard response and one quick response head. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 9, 2013.	K 062	K 062 Residents Affected All residents have the potential to be affected. Measures/Systemic Changes Authorized vendor will ensure sprinkler heads in the North HVAC equipment room meet code. Monitoring Changes Authorized vendor will confirm that all sprinkler heads meet code during quarterly inspections. Any future reports of non-compliance will be reported to Safety Committee Meeting (Nursing, Executive Director, Human Resources, Maintenance, Director of Clinical Education) monthly for (3) months and recommendations made as appropriate.	10/22/13
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure electrical outlets were maintained. The findings include: Observation and interview with the Maintenance Director, on September 9, 2013 between 8:00 a.m. and 2:00 p.m. confirmed the following deficiencies with electrical outlets: 1. Outlet in the exit alcove across from the DON office was loose, 2. Outlet next to the television at the North 200 hall sitting area was loose, 3. Outlet in the corridor by room 103 was loose, 4. Outlet in the private dining room was loose, 5. Outlet in the front corridor across from the	K 147		

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K 147	Continued From page 3 clean utility room was loose, and 6. Outlet in the corridor between rooms 200/202 indicated "open ground" when tested. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 9, 2013.	K 147	K 147 Residents Affected All residents have the potential to be affected. Measures/Systemic Changes Electrical contractor contacted. Outlets will be repaired/ replaced to meet code. Monitoring Changes Electrical outlets will be checked during interior round and monthly room inspections. Any future reports of non-compliance will be reported to Safety Committee Meeting: (Nursing, Executive Director, Human Resources, Maintenance, Director of Clinical Education) monthly for (3) months and recommendations made as appropriate.	10/22/13